

8. 'SEARCH II' in the United Kingdom

Drug use amongst refugees and asylum seekers using the Rapid Assessment and Response method (RAR)

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1. About the Organisation

The University of Central Lancashire traces its roots back to the Institution for the Diffusion of Knowledge founded in Preston in 1828. It developed through the Harris Institute and Harris College to become Preston Polytechnic in 1973. It became Lancashire Polytechnic in 1984 and was granted University status in 1992 when it became the University of Central Lancashire (UCLan).

UCLan now has around 30,000 students studying on the main campus in Preston, the Cumbria Campus, partner colleges across North West England and National Health Service sites throughout Lancashire. Students study full time and part time, on taught and research degree programmes. The University employs over 2,000 staff.

The University has five faculties: the Lancashire Business School; Cultural, Legal and Social Studies; Design and Technology; Health; and Science.

It offers a variety of courses, many of which reflect its strong links with industry, commerce and public service. It runs courses at access, HND, degree and post-graduate and research level. Modular study programmes allow students to build their degrees around their own interests and aspirations. Research work is undertaken which supports the teaching and learning programmes, much of it relating to the needs of local industry.

About the Centre for Ethnicity and Health, University of Central Lancashire, Preston

The Centre for Ethnicity and Health was founded in 1998 to address inequity in health and social care for Black and minority ethnic communities in order to improve service access, experience and outcomes. The Centre has four areas of expertise: research, teaching and learning, community engagement and organisational change.

The Centre currently consists of a multi-disciplinary team with a range of bilingual skills and extensive understanding of the UK's multi-cultural and multi-faith communities. The Centre's main activities lie in the fields of drugs and alcohol, mental health, community engagement, racist victimisation, regeneration and health, equality and diversity strategy development, and mental health law. To complement the Centre's research portfolio, teaching and learning activities are in continual development, with the aim of contributing to knowledge, expertise and good practice in the fields of ethnicity and health. The Centre has particular expertise in research and drugs, and trains and supports members of Black and minority ethnic community organisations to undertake their own research.

The Centre's research methods and results have a significant national and international reputation. National research has been commissioned by various government departments and international commissioners have included the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Department for International Development, and the United Nations Office on Drugs and Crime (UNODC).

2. The national and regional situation of migrants in the United Kingdom

The current climate in the UK is that of an 'asylum clampdown'. The current Home Secretary has vowed that asylum legislation will be 'tough' in response to popular perceptions that the UK is 'a soft touch' for applicants (TRAVIS 2003b). Measures are being taken to make entering the UK more diffi-

cult and to make the removal of those who fail with their asylum application easier and quicker. In addition, the social support that asylum seekers are entitled to is being reduced, and the use of detention and removal centres is being utilised more frequently.

Certain sections of the press media have inflamed the debate about asylum with sensational headlines. Although Britain, in terms of asylum applications in relation to the overall population, was ranked fifth in the EU in 2002 and accepts just 2% of the world's refugees (THE OBSERVER, 2002), the country's best-selling daily newspaper suggests 'Britain the No 1 refugee magnet' (THE SUN, 14 September 2002).

According to a recent Home Office study, asylum seekers made a net fiscal contribution to the UK of approximately £2.5 billion in 1999-2000. A recent report by the Greater London Authority suggests that 23% of doctors and 47% of nurses in the National Health Service (NHS)¹ were born outside the UK (Refugee Council, 2003b). However, there is fear expressed by certain media that asylum seekers are a drain on resources, including that of the National Health Service: 'Bogus asylum seekers are draining millions from the NHS' (DAILY EXPRESS, 26 November 2002).

The Department of Health is expected to confirm in the near future that it will abandon rules that allow anyone who has been in Britain more than twelve months to receive free medical treatment (HINSLIFF, 2003c). Ironically, hundreds of 'failed' asylum seekers were recently found to be working in the NHS, mostly as ancillary workers who are difficult to recruit from within the UK (HINSLIFF, 2003b).

The dispersal of asylum seekers and refugees to various geographical locations across the UK has resulted in local dissatisfaction and numerous attacks on them. The Crown Prosecution Service reports that it dealt with 20% more racially-motivated crimes in the year up to April 2002 than in the previous year, with anecdotal reports suggesting a rise in attacks against asylum seekers and refugees (BBC News Online, 2003). A number of murders of asylum seekers have also been reported in the media. The first to come to national prominence in recent years was that of Firsat Dag, a Kurdish refugee, who was killed on a housing estate in Glasgow in August 2001 (Ibid.). New accommodation centres are being built as an alternative to the current system of dispersing refugees across the country (TRAVIS, 2002). In addition, there is the introduction of induction centres where asylum seekers will be housed when they first arrive in the country, and removal centres where 'failed' asylum seekers will be kept in secure conditions until they are removed from the country. It is proposed that induction centres will provide basic health screening. However it is unclear whether any information given by individuals relating to drug use will be confidential and would not impact on their claim for asylum.

Chronology of UK immigration policies

Over the past decade there have been a number of Acts dealing with immigration.

In 1993 the Asylum and Immigration Appeals Act amended the 1971 Immigration Act. This Act placed restrictions on carriers (airlines, lorry drivers, etc.) to demand transit visas from passengers to ensure they do not disembark in the UK in order to claim asylum. The Act withdraws the rights for asylum seekers to apply for local authority housing² and to receive child benefit³.

1. The NHS is funded through taxation and is free at the point of access.
2. State-provided subsidised accommodation / social housing
3. All parents with children are entitled to child benefit of between £10 and £16 per week per child under 18 years of age.

In 1996 the Government attempted to remove all rights to state benefits for asylum seekers applying in-country⁴ but the Court of Appeal rejected this. In the same year the Asylum and Immigration Act received Royal Assent. The main provisions of this Act include accelerated procedures for removing asylum seekers from designated 'safe' countries⁵ and the removal of the right of appeal against return to a safe third country⁶.

In 1999 the Asylum and Immigration Act extended carriers liability including new measures to refuse entry to undocumented passengers, introduced a system of social housing and support centralised under the National Asylum Support Service (NASS) for new asylum seekers. The Act also introduced the dispersal of asylum seekers to designated cluster areas across the UK and a centralised system of benefits in the form of vouchers was introduced.

The Nationality, Immigration and Asylum Act 2002

The most recent major piece of legislation, the Nationality, Immigration and Asylum Act (2002) introduces:

- new criminal sanctions for those who destroy travel documents en route to the UK;
- the withdrawal of state benefits for rejected asylum seekers who repeatedly refuse to leave the UK;
- a single tier of appeal only (asylum seekers are deprived access to the Higher Courts);
- a two-stage plan to 'massively restrict' legal aid (state provided legal assistance);
- electronic tagging (tracking system) of those facing deportation; and
- an extension to the list of designated 'safe' countries.

Since July 2002 asylum applicants are no longer able to work or undertake vocational training until they are given a positive decision on their asylum application, irrespective of how long they wait for a decision.

Under Section 94 of the Act, people may have their asylum application certified as 'clearly unfounded' and be removed to their country of origin prior to appeal. This means that the asylum applicant is denied an in-country right of appeal.

The Nationality, Immigration and Asylum Act 2002 introduces a requirement for refugees to attend citizenship lessons and emphasises the need for asylum seekers to learn a British language. This Act allows for the establishment of accommodation centres where hundreds of asylum seekers will be placed and requires those asylum seekers living in the community to report regularly to the police or immigration authorities. If they do not comply they risk losing any social support and housing the state has provided. The National Asylum Support Service (NASS) will not support those who do not claim asylum 'as soon as reasonably practicable', in effect leaving them destitute. The Act also simplifies the process of removing those who have applications rejected.

4. These are applicants who have already entered the UK - they are not claiming asylum at point of entry.

5. The 'white list' of countries the Government deems to be safe for refugees to return to.

6. Where an asylum seeker has travelled to the UK via another designated 'safe' country.

The new Immigration and Asylum Bill (first announced in October 2003) plans to remove all state benefits and social support from 'failed' asylum seekers, which does not preclude the state from removing children from their families 'for their own welfare'.

Recent Government statistics on asylum

- There were 84,130 applications (excluding dependants) for asylum in 2002. This is a rise of 18% from 2001.
- The main countries of origin were Iraq, Zimbabwe, Afghanistan, Somalia and China.
- Asylum was granted in 10% of cases and exceptional leave to remain⁷ awarded to 23% of cases.
- There were 65,405 appeals against refusal of asylum of which 22% were allowed to proceed.
- Following appeal, 10% were granted asylum.
- In 2002, 68% of asylum applications were made in-country

(All figures taken from HEATH, JEFFRIES AND LLOYD, 2003)

It is difficult to estimate the number of 'illegal migrants' in the UK. The Home Secretary recently admitted that he has 'no clue' of illegal immigrant numbers (WOOLF, 2003). MATHER (2002) suggests that asylum seekers going missing while being dispersed to regions across the UK has resulted in 'hundreds of thousands of illegal migrant workers in Britain'.

The Government recently pledged to reduce asylum applications by half and figures released on 27 November 2003 saw the number of applications to the UK fall by 52%. There were 11,955 applications between July and September 2003, down from 22,030 between the same period in 2002. (PRESS ASSOCIATION, 2003).

The Government has also pledged to reduce the cost of legal aid given to asylum seekers (this is state funding for legal appeals). 'The Department of Constitutional Affairs has drawn up a two-stage plan to cut the legal aid bill for asylum and immigration cases which has risen from £83m to £174m in the last two years'. (TRAVIS, 2003c)

3. The situation of refugees and asylum seekers in the UK - Literature review

In the UK, asylum seekers only receive 70% of the state benefits usually allowed to those who are unemployed and low-paid. This situation reflects the government's intention that providing a low level of financial support will discourage those who seek asylum because of extreme poverty rather than from fear of persecution (AUDIT COMMISSION, 2000).

This financial deprivation is likely to be exacerbated by a recent decree from the Home Office, where-

7. The replacement of exceptional leave to remain by a 'humanitarian protection' status became effective in November 2002

by asylum seekers applying after 23rd July 2003 are prohibited from working until they are granted a positive decision (ie awarded 'exceptional leave to remain' or refugee status) on their asylum application. This provision does not take into account the length of time an asylum seeker may wait for a decision, which may be many months.

Variations in practice between regional local authorities also affects the financial hardship faced by unaccompanied minors: support for some young people may be provided wholly through meals and accommodation without financial assistance available for costs such as travel and resources for education (STANLEY, 2001).

The high cost of living in some areas such as the South East of England has led to some local authorities dispersing asylum seekers to other parts of the country. Support structures to facilitate asylum seekers' access to services (housing, education, social and health care, etc.) may be lacking in a number of geographic areas. The formal policy of dispersal, applicable to adult asylum seekers and some minors, can, however, place additional restrictions on available support. Unaccompanied minors may be particularly vulnerable to the unavailability or inaccessibility of support when dispersed (KIDANE, 2001) and there may be wide variation between local authorities in the adequacy of the support package a young asylum seeker will receive (BARNADOS, 2001). Asylum seekers may be dispersed to areas that have little experience of providing for these communities and may not have a sufficient infrastructure available to provide adequate support (AUDIT COMMISSION, 2000). Dispersal throughout the UK, to regions where Black and minority ethnic communities are smaller and less well established, may also bring with it the risk of conflict with indigenous communities (DENNIS, 2002).

Young people

Young refugees and asylum seekers may have experienced many or multiple stressors and traumas, 'including physical harm, intimidation or other forms of psychological trauma, loss, deprivation, malnutrition, separation from family members, bereavement, or abuse' (BERMAN, 2001). STANLEY (2001) reports, however, that many services for children are 'accommodation focused'. Further research by the AUDIT COMMISSION (2000) and DENNIS (2002) show that many children are being placed in inappropriate accommodation often aimed at 'single adults'. KIDANE (2001) has noted that 'as most unaccompanied children arrive at a potentially stressful stage in their development, they are vulnerable to trauma and particularly sensitive to insecurity'.

Unsatisfactory care (for example, with inadequate adult support and supervision) arrangements could also endanger the safety of children who, in their search for someone to belong to, could fall prey to inappropriate relationships (attachments) that might exploit their vulnerability. Some local authorities also lack specialist child asylum seeker teams, which appear to be an important factor in children being enabled to form relationships with social workers (Stanley, 2001). Furthermore, Stanley highlights that frequently those children who are accorded 'looked after' status⁸, have less contact with a named social worker. Prospects for social interaction, development and support are hampered further by restricted access to appropriate opportunities and resources in education. Consequently, the needs of young asylum seekers, particularly those who arrived unaccompanied, are not always fully met and they may, therefore, be seriously at risk of social exclusion.

8. In England and Wales, Section 17(1) of the Children Act 1989 requires local authorities to 'safeguard and promote the welfare of children within their area who are in need.' Section 20(1) states that 'every local authority should provide accommodation for any child in need, who appears to them to require accommodation as a result of there being no person with parental responsibility for them.'

Government statistics state that 6,200 unaccompanied children applied for asylum in 2002 (HEATH, JEFFRIES and LLOYD, 2003). Main countries of origin for unaccompanied children are Afghanistan, Federal Republic of Yugoslavia (FRY), Somalia and Iraq (HEATH and HILL, 2002). It is estimated that around 40% of refugees in the UK are children (HODES, 2000). The number of unaccompanied minors amongst them is unclear, although there are several estimates, ranging from 3,350 to 10,000 (AUDIT COMMISSION, 2000; HODES, 2000; AYOTTE and WILLIAMSON, 2001; SOMERSET, 2001; UNICEF, 2001; HEATH and HILL, 2002; HEATH, JEFFRIES and LLOYD, 2003).

3.1. Immigration and addiction

3.1.1. The research team and the research process

The RAR team consisted of two researchers supported by colleagues within the Centre for Ethnicity and Health. Before embarking on the study, we obtained ethical approval for the work from the University of Central Lancashire's Faculty of Health Ethics Committee. We began by analysing previous research that had been conducted on substance use amongst asylum seekers and refugees by looking at media reports in this area and conducting a literature review.

A number of key individuals were identified from the literature and contacts within the Centre for Ethnicity and Health. These individuals were approached by telephone or email and asked if they would participate. Then, if they agreed, semi-structured interviews were conducted with key informants. The interviews were a combination of face-to-face and telephone interviews. In a number of interviews, one researcher conducted the interview while the other took notes. A single interviewer conducted some interviews over the telephone if the interviewee was located in another part of the country. The SEARCH RAR schedule for semi-structured interviews was followed, with slight adaptations to fit into the British perspective of drug use. Once the interview was completed, individuals were asked if they knew of other people we could interview and other contacts were followed up.

3.1.2. Literature Review

Introduction to refugee and asylum seeker drug use

Within the UK, little research has been conducted on the extent of drug use amongst refugees and asylum seekers, and there is little published literature in this area. Most recently the Home Office has published a report which aimed to scope the incidence of drug use amongst these communities and the implications for the provision of services (CRAGG ROSS DAWSON, 2003).

The Centre for Ethnicity and Health has recently conducted research looking at drug use amongst young asylum seekers and refugees in London (Patel et al., 2004). The research takes account of the known risk and protective factors for drug use amongst these young people, and examines the relevant national and local policies that should act as protective factors.

The Home Office report (CRAGG ROSS DAWSON, 2003 pp. 20-1) states that

'refugees and asylum seekers are not a homogeneous group and propensity to become involved with drugs depends on many factors. However, the attention of those concerned with this issue tends to focus on four principle areas of concern. In no particular order, these are: khat use by refugees and

asylum seekers from Somalia and other East African countries⁹; unhealthy dependence on prescription drugs, particularly by women from Asia; addictions resulting from coerced use of drugs, either in warfare or as a means of forcing women into prostitution; and the particular vulnerability of some national/ethnic groups, notably from Eastern Europe and Turkey, of being recruited by drug dealers.'

Incidence of use

CRAGG ROSS DAWSON (2003) report that problematic drug use amongst newly-arrived asylum seekers and refugees is a relatively rare occurrence. However, the authors concede that 'very little is known for certain about how many refugees and asylum seekers have drug dependency problems', largely due to a dearth of dependable data from agencies such as drug services, the National Health Service and the police and criminal justice services. Similarly, data from the Centre for Ethnicity and Health also reveals that drug use and problematic substance use is low amongst young people in this group (PATEL et al., 2004)

CRAGG ROSS DAWSON (2003 p. 3) highlight that 'refugees and asylum seekers very rarely access services, but this does not mean they are not in need of them'. Information on the use of substances by asylum seekers and refugees is hampered not only by underreporting and unwillingness to present to services (because of fear and stigma), but also the likelihood that such substance users may not access any statutory or non-statutory groups or services.

Use of substances and amongst different groups

Research suggests that the use of substances and the type of substances used vary according to factors such as: the length of time a community has been in the UK; the cultural acceptability of certain substances; the type of community; age; gender; and the availability of substances. An accurate picture of substance use by asylum seekers and refugees is difficult to determine because the data which are available are often based on anecdotal reports from workers in the drugs and community fields, many of which will have focused on a particular community or geographical area.

SANGSTER et al. (2003) suggest that there is reason to suggest there is drug use, some of which is problematic, in a number of recently established Black and minority ethnic communities with a large number of recent migrants. Amongst the Vietnamese communities involved in their study, opiate and crack cocaine use is reported, while amongst the Somali communities the use of opiates and crack cocaine is also highlighted, but to a lesser extent than in the Vietnamese communities.

There is some evidence to suggest that khat chewing, although a legal substance in the UK, is becoming problematic amongst some communities (GRIFFITHS, 1998; WHITTINGTON and ABDI, 2001). Its use is associated with the Somali community in the UK, but is also used by people from the Yemen, Ethiopia and Eritrea.

Research into the use of khat has highlighted a number of key factors associated with its use. These include a high rate of unemployment in the Somali community, the loss of culture and cultural roles,

9. Khat (quat, qat, chat, qu'at, *Catha edulis*) is a perennial shrub traditionally cultivated in Ethiopia. The leaves and young shoots of the plant are chewed for their stimulant properties. Traditionally it has been popular in countries where other intoxicants are prohibited because of religious beliefs. Khat chewing sessions are usually social affairs. Khat contains cathine and cathinone which are psycho-active (similar to amphetamine but less strong).

particularly for men who have lost their traditional role as providers for their families, and a removal of cultural restrictions which previously discouraged use by women and young men under the age of 21 years. Khat use has long been associated with religious worship and particularly men still primarily use it in a social context (a khat user's house may have a designated 'khat room'). However, the environment where men often meet carries a number of health risks as ventilation points are sealed to improve the smoking experience and cups are shared which may lead to infection due to the smoke and heat in the khat room (WHITTINGTON and ABDI, 2001 p. 16). The stigma attached to khat chewing for women has led to many women chewing khat in their own homes, which means as invisible users they may be ignored in preventive interventions, services and education. It is also reported that younger khat users have further progressed to other available drugs and some have become involved in dealing and other criminal activities to fund their usage (SANGSTER et al., 2003 p.19).

Young people

In a recent report from the Centre for Ethnicity and Health (PATEL et al., 2004), interviews were conducted with 67 young asylum seekers and refugees aged 16-25 years of age in the London area. These young people were originally from Africa, Nepal, Afghanistan, Turkey and Iraq. Current problematic drug use amongst them was reported to be low. Some had used drugs prior to entry in the UK and current use was largely centred around cannabis, although a small minority used a number of other substances, including alcohol, crack, heroin and ecstasy. A number of interviewees reported that they had discontinued any drug use after their arrival in the UK. In addition, a small number of participants reported involvement in the sale of illicit drugs.

There are reports that the initiation of drug use for recreation purposes has become a 'normal' part of growing up in the UK. McDonald and Marsh state that 'the findings of a range of national and regional social surveys are claimed to show that the use of an illicit drug by early adulthood is becoming a statistical probability' (MCDONALD and MARSH, 2002 p. 29). It is estimated in the British Crime Survey that 47% of 16-24 year olds have used an illicit drug and 17% have used a Class A drug at least once in their lives (CONDON and SMITH, 2003). As young refugees and asylum seekers become integrated into their local communities, their patterns of drug use may reflect those of the indigenous communities. For example, research by Abdi and Whittington (2001), based on interviews with community workers and community members in London, report that Somali young people were using khat but also cannabis, cocaine and heroin. This finding was further substantiated in reports by drug workers in SANGSTER et al. (2003) that young Somali men reported opiate use. Such findings support the suggestion made by the Centre for Ethnicity and Health (PATEL et al., 2004) that patterns of drug use may vary with time spent in the UK.

Reasons for using substances and the associated risk factors

Social circumstances

The small number of studies which exist from both academic and unpublished (grey) literature indicate that asylum seekers and refugees in the UK are not provided with necessary levels of social support. These groups may suffer from social exclusion; a poor physical environment; inadequate housing; lack of access to education, training and health facilities; and financial deprivation (PATEL et al., 2004). FLEMEN (2003) also notes that refugees and asylum seekers are settled in areas of 'high urban deprivation' and are likely to experience high availability of drugs. Furthermore, financial deprivation and restrictions placed on asylum seekers gaining employment may lead to 'engagement in underground economies' (FLEMEN, 2003 p. 14). Consequently, the implications of resettlement in the UK are far-reaching and SANGSTER et al. (2003 p. 19) argue that 'settlement in Britain has presented these com-

munities with new challenges in relation to drugs'. For example, the Bangladeshi Youth Forum, a community organisation that conducted research among the Bangladeshi community in Birmingham as part of the Centre for Ethnicity and Health's Community Engagement project (see WINTERS and PATEL, 2003; BASHFORD, BUFFIN and PATEL, 2003), report that:

'The Bangladeshi community are one of the last groups to come to Britain from the South Asian continent, in addition to being one of the poorest, and as such are having to adapt to cultural transition at a feverish pace. It is well documented that many drug problems are experienced and get a 'foothold' where a culture is in 'transition'.' (AJID et al., 2001 p. 45)

Given that many asylum seekers are living in a poor social environment in the UK, they are vulnerable to many of the risk factors identified as pertinent in problematic drug use, whether these are licit prescription drugs or illicit drugs (HAWKINS, CATALANO and MILLER, 1992; SUSSMAN, DENT and GALAIF, 1997).

Young refugees and asylum seekers interviewed for the Centre for Ethnicity and Health study (PATEL et al., 2004) cited a number of reasons for using drugs. Many of these are related to the social environment in which they have found themselves and include peer pressure; emotional suffering and problems; depression; feelings of isolation from society; loneliness; boredom and excessive free time; family pressures and problems; lack of status (i.e., a decision on asylum application); and the wide availability and use of drugs in local environments. A number of respondents in the study expressed the opinion that having greater access to a number of substances increases the likelihood of them experimenting with them.

Notably, these young people reported that they had no formal drug education. Their knowledge of drugs was gained through personal experience of their own or others' drug use and from various media.

The cultural use of drugs

SANGSTER et al. (2003 p.18) argue that 'drug use within these communities [asylum seekers and refugees] reflects collective cultural experiences which preceded settlement in Britain'. FLEMEN (2003 p.14) also notes that asylum seekers and refugees may arrive from countries that already have 'indigenous substance misuse issues'. He reports that 'many countries across the world have moderate to high levels of substance misuse and these often develop in situations of social breakdown, poverty and deprivation' (ibid.). For example, Sangster et al. (2003) report that amongst the Vietnamese community, an 'older' group of users were described as having started to inject opiates while they were in refugee camps in Hong-Kong. Some refugees and asylum seekers may also have had experiences with drugs due to their experiences of conflict in their homeland where drugs may be used as a method of controlling prisoners and soldiers (BASHFORD, BUFFIN and PATEL, 2003).

Use of traditional substances may serve to maintain cultural identity and provide a means to deal with a range of issues surrounding cultural dislocation. Research by the Somali Health and Mental Health Links group reported in BASHFORD, BUFFIN and PATEL (2003 p. 23) suggests that 'cultural dislocation' within the Somali refugee community may play a role in their involvement with drugs: 'cultural dislocation within the Somali refugee community, and racism within the wider community, which may lead individuals to see khat as a refuge, either as an escape or as a means of boosting self-esteem'.

As noted, above, there is some evidence that asylum seekers and refugees may adopt the cultural drug-using patterns of the UK once they have been living in the country for a period of time (ABDI and WHITTINGTON, 2001; PATEL et al., 2004).

Mental Health Difficulties

It has been suggested that mental health difficulties incurred as a consequence of experiences prior to, and following, migration to the UK may be a contributory factor to drug use. For example, respondents in SANGSTER et al. (2003) reported a link between drug use, PostTraumatic Stress Disorder (PTSD) and mental health difficulties in Somali and Vietnamese groups.

While mental health difficulties may be a common occurrence amongst refugees and asylum seekers due to past and current events, the applicability of western diagnostic frameworks such as PTSD has been questioned by academics such as SUMMERFIELD (2001). Nevertheless, a national study of asylum seekers who have been granted refugee status conducted by Carey-Wood et al. (1995) revealed that two thirds of respondents interviewed stated they were experiencing anxiety or depression. Those who had poor English or were unemployed were particularly likely to say they felt anxious and depressed. The most likely causes for depression were attributable to problems in the country of origin, although a sizeable proportion also reported the inability to find employment in the UK was also a factor. A number of studies also suggest that certain groups of asylum seekers may be at an elevated risk of mental health difficulties. A study by AGER et al. (2002 p.75) with 26 refugee and asylum-seekers in Edinburgh, who were acknowledged by Scottish Refugee Council service staff as being at risk of social exclusion, found that 54% 'scored at a level associated with formal clinical diagnosis of anxiety disorder', while 42% 'scored at a level associated with formal clinical diagnosis of depression'. Those respondents who had been in the UK for over two years were nearly twice as likely to report 'case' levels of depression and anxiety, with higher levels of case depression and anxiety found amongst single people. Furthermore, international research has suggested that young refugees and asylum seekers may be particularly at risk of developing mental health problems, with unaccompanied minors being particularly vulnerable (MCCALLIN,1992; SOURANDER,1998; LOUGHRY and FLOURI, 2001).

It has been suggested that licit and illicit drugs may be used by asylum seekers and refugees as a means of self-medication to alleviate physical and mental health difficulties. A study conducted by the King's Fund (WOODHEAD, 2000 p.2), which consulted a small number of non-governmental and statutory sector organisations providing services for refugees and asylum seekers in London, reports 'unofficial self-medication (e.g. through alcohol and street drugs) often helps victims cope with the psychological effects of torture and war'. Reports by the Health Education Authority Expert Working Group on Refugee Health (1998) and by WHITTINGTON and ABDI (2001) also suggest that substances may be used as a coping strategy. In addition, certain practices in a person's country of origin may allow for the prescription of large doses of drugs to manage negative psychological affect. Substances in this quantity may not be available in the UK legally, which may create the need to obtain prescribed drugs illegally. Drugs obtained through these means will not be accompanied by professional guidance in safely using them.

Barriers to accessing services for problematic drug use

FLEMEN (2003 p.14) outlines a number of barriers that may discourage asylum seekers and refugees from disclosing substance use:

- Substance use may not be considered when assessing the health or other needs of asylum seekers and refugees;
- Fear that disclosure will affect asylum applications or status;

- Fear of imprisonment or punishment due to the heavy penalties attached to substance use and supply in many parts of the world;
- Fear of social stigma attached to substance use and dependence;
- Users may not perceive a drug as problematic due to cultural norms;
- Users are not aware of drug services;
- In many countries outside the UK (and Western Europe), 'treatment is simply not available, and elsewhere may be unaffordable, brutal, basic, or a combination of all three'.

Furthermore, FLEMEN (2003) suggests that once a drug problem develops, this group faces further barriers to accessing help or drug services because of fear of punishment, stigma, demonisation, language barriers and unfamiliarity with services. Drug service providers may not be familiar with particular substances used by refugee and asylum seekers.

3.2. Immigration and addiction: *First results from RAR*

The key individuals

The researchers conducted semi-structured interviews with the following individuals who were involved with asylum seekers or refugees:

- 1 policy-maker (London-based)
- 2 managers/workers in drug services (Northern England-based)
- 2 community group researchers (Northern England-based)
- 1 education/youth worker (Central England-based)
- 1 community group worker (London-based)

Each of these individuals either worked directly with asylum seekers and refugees or managed programmes targeted at these groups. Owing to the short period of time the RAR team had to conduct this study, we could only interview 7 individuals but we were fortunate that they possessed a good knowledge about asylum seekers, substance use, and the related issues. We tried to speak to the major voluntary organisations regarding asylum seekers, but were unable to do so in the time and resources allowed for the project.

Initially, it was difficult to get some potential interviewees to participate; many said that they did not know enough about substance use among asylum seekers. Therefore, our initial plan to focus particularly on unaccompanied (separated) children and young people was made very difficult. Following semi-structured interviews, it is difficult to pinpoint the most 'at risk' group. However, the use of khat is mentioned by the majority of interviewees, reflecting current concern in this area amongst policy makers, drug agencies and some refugee groups. It is worth noting that khat is a legal substance in the UK and used by only a small number of refugees.

The interviewees were located across England. Asylum seekers are generally dispersed across the UK, although the greatest numbers are located in London. This report aims to provide an overall view of asylum seekers, refugees and substance use across the UK rather than in just one geographic area.

What agreement was there on the use of substances by this group?

The majority of the interviewees agreed that there was little use of substances among asylum seekers in the UK, and it was unusual for their use to be problematic. A number of interviewees mentioned Class A drug use but these were cited as rare occurrences. One interviewee, who worked in drug services, suggested that around one-third of young asylum seekers were using substances, but again stressed this was not likely to be problematic use. The education/youth worker interviewed suggested that around 50% of Somali young people were using khat, but again, that this use was generally unproblematic.

The two individuals who worked in research suggested that those young people who volunteer to take part in research studies are those who are least likely to be using substances in a problematic way, and therefore the true extent of the problem may be hidden. This highlights the need for asylum seeker and refugee groups to conduct research amongst their own communities, with the training and support such as that offered by the Community Engagement project at the Centre for Ethnicity and Health (WINTERS and PATEL 2003; BASHFORD, BUFFIN and PATEL, 2003). Using this approach, asylum seekers and refugees can 'own' the research, focus on the issues that are most relevant to them, and are less likely to feel further stigmatised by outside 'experts'. The approach also encourages and builds on the capacity of the organisations involved.

What substances were being used?

A number of substances were mentioned by interviewees, the most frequently mentioned were heroin and crack, khat and cannabis. Also mentioned were paan (a mild stimulant which is a mixture of spices used with betel nut), alcohol and a substance that was reported by Nepali young people (a cough mixture unknown in the UK).

Who are using these substances?

- Crack was mentioned in relation to women in the sex industry from Eastern Europe.
- Cannabis was mentioned in relation to young people, and also to adults.
- Khat was mentioned in relation to the Somali community mostly, but also to Yemeni and Ethiopian communities in the UK.
- Alcohol was mentioned in relation to older Afghans.
- Kurdish and Turkish young people were also mentioned in relation to drug use.

What are the psychological, physical, social, financial and law-related effects of using substances?

A number of interviewees spoke specifically about the effects of using khat:

- Interviewees reported that heavy khat use could result in eating and sleeping problems (due to its amphetamine-like qualities).
- Interviewees highlighted that heavy khat users are not likely to be working and they can withdraw from society owing to the large amount of time they dedicate to chewing.

- However, interviewees also said that chewing the plant (which is traditionally consumed in the company of others) gives asylum seekers a cultural identity and is not necessarily seen as problematic by those who use it.
- Interviewees reported that using khat within the context of unemployment was an issue and there may be financial problems for users if they are spending what little money they have on khat. Interviewees said that the use of khat had been linked to domestic violence and the necessity to obtain money to buy the plant could result in involvement in crime.
- One interviewee suggested that, in one area, there were links with prostitution.

Substance use in general

Interviewees also spoke more generally about the effects of substance use, suggesting that asylum seekers might use drugs as a coping mechanism to combat depression, isolation and stress. There was mention of gang related activities amongst Kurdish and Turkish asylum seekers particularly related to drug dealing. However, when interviewees were asked about asylum seekers or refugees being involved in drug-related crime, a number of interviewees stressed that asylum seekers were likely to be the victims of crime, particularly racially motivated attacks and harassment.

What factors influence substance use in the homeland and host country?

Differences in use between the homeland and the host country.

In considering the use of other substances, interviewees mentioned that more substances are available in the UK than in most countries of origin and some interviewees suggested that asylum seekers were not always aware of what substances were illegal in the UK.

In considering khat, a couple of interviewees stated that the use of khat is very different in the homeland than it is in the UK. It is socially acceptable in Somalia (and the Yemen and other African countries where it is used) but its use has been pathologised in the UK. Another interviewee suggested that khat use was problematic in the UK because of the social context within which it is used (for example, unemployment and housing problems).

With regard to young people, interviewees noted that the influence of the family is diminished or non-existent: they may be in the UK without their families and their sudden independence and lack of restrictions that operate in their homeland may make them vulnerable to drug use. Another interviewee added that those asylum seekers who are not integrated with the indigenous population might be more protected than those who are integrated from using drugs.

Function and benefit of using substances

One interviewee suggested that some asylum seekers are experimenting with substances because they were experimenting with integration: using drugs could be part of becoming accepted by the indigenous population. Other interviewees also said that using substances could help to form an identity and can foster a sense of belonging – ‘it is what others do’.

Interviewees also mentioned that substances can be used as self-medication, a means to ‘turn it all off for a while.’ Many asylum seekers have had very traumatic experiences involving torture, death of family members and hazardous journeys to the UK and may use drugs to escape from memories of the

past and the difficulties of their present situation, and the uncertainties of the future. As one interviewee said:

'it is the experiences of asylum seekers that makes them vulnerable to drug use. Young people arrive without their parents and often talk about being isolated and depressed. They are separated from their families who may be dead, and they may have seen them being killed. Some arrive and do not get plugged into services – they get approached by, or latch onto, complete strangers just because they speak the same language.'

What do asylum seekers and refugees know about the risks of substance use?

Overwhelmingly, the interviewees suggested that asylum seekers knew little of the risks associated with substance use. Interviewees suggested that this might be due to unfamiliarity with some of the drugs available in the UK. For example, one interviewee reported that asylum seekers were confused about the legality of cannabis (although this could be due to recent amendments to UK laws surrounding the possession and use of cannabis making it a less serious offence to possess small quantities). A couple of interviewees noted that there was especially a lack of information regarding khat use. One said 'there is no information on khat use. It is not seen as a problem to take action on. Agencies target Class A drugs use. Drug education at school... does not include khat use.'

A couple of interviewees mentioned that for Muslim asylum seekers, their religion prohibited the use of substances and therefore they are taught only that, 'taking substances is wrong and that is all they need to know'.

What are the existing preventive conditions and/or preventive interventions to minimise the involvement of asylum seekers and refugees with substance use?

When this question was asked, most interviewees answered with what should be in place or questioned whether there were any preventive conditions or interventions currently in place for asylum seekers.

One interviewee said that young asylum seekers who go to school would receive drug education at school. Another interviewee said that Drug Action Teams (DATs) conducted needs assessments with newly-arrived asylum communities, and this would look at the needs of the group regarding drug services, although another interviewee suggested that the depth of this intervention may vary between regions.

Other interviewees mentioned that strong links to community groups and religious networks could provide asylum seekers and refugees with support and this might have a preventive effect with regard to using substances.

What prevention is needed?

The responses to the question about what prevention is needed varied from specific drug prevention and education, through to wider social needs. One interviewee felt that there needed to be information available that was interpreted into the required languages. Another interviewee felt that harm reduction interventions were needed.

Most interviewees spoke about the social conditions for asylum seekers and refugees and how these

needed to change if preventing substance use was to be successful.

Interviewees said that asylum seekers and refugees needed better living conditions, good housing, decent employment and to be able to contribute to society.

One interviewee noted that asylum seekers and refugees 'need to learn to speak English in order to participate fully'.

One interviewee said that access to mental health services for asylum seekers and refugees needed to be improved. Another said that many asylum seekers were not registered with a family doctor, who would be able to refer them to mental health services if necessary.

A couple of interviewees discussed the process of claiming asylum. They said that this process needed to be quicker in order to reduce the amount of time that asylum seekers could not work or participate in society while their claim was being dealt with.

What are the priorities in prevention?

Interviewees gave a number of responses to the question 'what preventive interventions are needed?' Again, these tended to focus on the wider social responses that were required for prevention.

One interviewee said that women needed to be targeted more, as their use of substances was generally hidden. This same interviewee said that any interventions needed to target the partners and families because they may collude with women to hide their drug use because of the associated stigma or for economic reasons. The interviewee spoke about Eastern European women who worked in the sex industry and said that this was a 'hard-to-reach' group because of the environment in which they lived and worked.

There was a consensus amongst interviewees that tackling social problems such as housing and unemployment were the priorities in preventing asylum seekers and refugees from involvement with substances.

A number of interviewees also placed an emphasis on the asylum application procedure. There was a belief that the attitude and culture towards asylum seekers needs to change. One interviewee said 'we need to treat asylum seekers better. Making conditions so bad for them that they won't want to come to Britain is not conducive to preventing drug use.' Another interviewee said that asylum seekers need a more positive experience on arrival in the UK. The importance of prevention is particularly important given the belief, held by a number of interviewees, that substance use amongst recently-arrived asylum seekers might be low, but was likely to increase. One interviewer said that those asylum seekers who had been in the UK for a while were more 'cynical and hardened' than those who were newly-arrived and this could have an impact on possible future drug use amongst them: as another interviewee said 'they [asylum seekers] have all the classic risk factors [for involvement in drug use].'

Another interviewee highlighted the gaps in services for newly arrived asylum seekers and said that it was easy for them to end up alone and unsupported in the UK. The interviewee suggested that properly funded community centres, where there is access to a range of services, might be a good way of supporting those who have just arrived in the UK.

4. Conclusion

Key points from the research

With a couple of qualified exceptions (two interviewees suggested that drug use was more frequent than others did), the consensus was that the use of substances amongst asylum seekers and refugees is low. None of the interviewees felt that substance use amongst these groups was problematic, although it was believed that a wide range of substances were used. The exception was khat, which was mentioned frequently by interviewees as being problematically used amongst Somali and Yemeni communities in the UK (currently, there is no evidence to suggest that khat is being used outside these communities). Further research needs to be conducted to ascertain the extent to which the emphasis on the use of khat among a small number of refugees and asylum seekers in the UK is obscuring other drug use amongst these communities.

Interviewees

- stated that there were differences in the types of substances that were used in the UK and those used in the homelands.
- felt that the social context of substance use in the UK was likely to make this use problematic for some refugees and asylum seekers in the future.
- highlighted a number of reasons for asylum seekers and refugees using substances and that their knowledge of the risks involved was low.
- did not feel that there were many preventive conditions or interventions in place for asylum seekers.

The preventive conditions and interventions that interviewees felt were needed to prevent substance use amongst these groups included better living conditions, more social inclusion and better support throughout the asylum application process.

Recommendations

The following recommendations were made by the key individuals interviewed in the RAR:

- Asylum process to be made quicker.
- Asylum seekers and refugees to receive more support.
- Increase the ability of asylum seekers and refugees to contribute to society.
- Better living conditions, housing, employment and access to services, including health and mental health services.
- Regarding drug services, most interviewees focused on education and prevention rather than treatment.

The following recommendations are drawn from the literature reviewed as part of the RAR process.

Social Issues

- The risk factors for problematic drug use centre on social exclusion and deprivation, and asylum seekers and refugees are highly likely to be vulnerable to these living conditions (FOUNTAIN et al., 2003; PATEL et al. 2004).
- Drug education to be fully integrated targeting in particular community groups and encompassing wider issues than just drugs (BASHFORD, BUFFIN and PATEL, 2003).
- Increased training, education and employment opportunities to break the cycle of deprivation and associated drug use (BASHFORD, BUFFIN and PATEL 2003).

Partnership and multi-agency working

- Multi-agency, outreach work, community engagement (FOUNTAIN et al., 2003)
- 'It is necessary to establish networks and partnerships working between drug agencies and the Kurdish, Turkish and Turkish Cypriot community organisations.' (BEKTAS et al., 2001 p. 61)
- Capacity building to enable communities to fully participate (BASHFORD, BUFFIN and PATEL, 2003).
- 'There is a need for drug service providers to develop further partnerships and work with other agencies in the statutory, voluntary and community sectors, especially BME community organisations given the reluctance of Refugees and Asylum Seekers to approach statutory service providers directly, and as a consequence make serious contributions to reducing drug misuse from a multi-agency perspective.' (BECTOR 2001 p. 60)

Promoting cultural sensitivity and addressing racism

- Drug workers etc. should have a knowledge of substances used in target countries/groups and drug trends in the UK e.g. patterns and cultures of use (FLEMEN, 2003).
- The Race Relations (Amendment) Act 2000 challenges all public services to eradicate discrimination and disadvantage and it requires public organisations to have clear race equality action plans. This provides the impetus for drug services to address the shortfalls in the provision of appropriate and accessible services for these groups (FOUNTAIN et al., 2003).
- In order for drug services to meet the needs of the Black and ethnic minority communities, they will have to be set within a context of addressing institutional racism (SANGSTER et al., 2003 p.54).
- Drug education materials need to be produced in community languages and for them to be culturally sensitive (BASHFORD, BUFFIN and PATEL, 2003).
- Drug education using different media and non-written formats (BASHFORD, BUFFIN and PATEL, 2003)

Access to services

- Barriers to accessing services are identified as the lack of acknowledgement of drug use by these groups themselves, ethnicity of staff, lack of understanding of minority ethnic cultures, language, lack of awareness of services, breaches of confidentiality (FOUNTAIN et al., 2003).
- Greater liaison between GPs, mental health teams and drug services, with greater knowledge 'of key substances used in target countries, and likely issues for care' (FLEMEN, 2003).
- *'We strongly recommend in the Qat issue that the Government should enable Yemeni communities in the UK and other groups concerned with the Qat issue to start addressing this problem in the community level through education, activities and awareness campaigns.'* (AL-KASH et al., 2001 p.104)

5. Next steps

This study has tracked the current situation on drug use and related services for asylum seekers and refugees in the UK, using the relevant literature and media reports and interviews with a number of key individuals. This work needs to be followed up with a detailed research study involving asylum seeker and refugee communities themselves. The follow-up work needs to further examine the extent of substance use amongst these groups and is necessary because, as a number of interviewees in the RAR pointed out, there is not enough research in this area, and the research that is conducted may under-report substance use amongst asylum seekers and refugees. The study then needs to look at the appropriate preventive conditions and interventions to reduce substance use amongst these communities.

It is particularly important that the asylum-seeking and refugee communities are supported in conducting their own RAR, by use of the Community Engagement model (see WINTERS and PATEL, 2003 and BASHFORD, BUFFIN and PATEL, 2003). This would allow groups of asylum seekers and refugees to own their own research – it isn't done 'on' them and they have some influence on the outcomes of the study. If groups themselves conduct the RAR there may be more accuracy in responses as they will feel less stigmatised, and can overcome many of the problems of access and language that regularly hinders research this area.

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